Head-to-Toe Physical Assessment

Establishing a good physical assessment would later-on provide a more accurate diagnosis, planning and better interventions and evaluation, that's why it's important to have a good and strong assessment.

Objectives:

After the end of this lesson, students are expected to:

- describe the basic understanding of assessing a patient
- demonstrate the basics of a head-to-toe assessment

Warm-up questions:

1. What do you mean by head-to-toe assessment?
2. What are the things that you need to prepare before assessing a patient?
3. Do you think it is necessary to properly assess the patient? Why/Why not?

Introduction

As the name suggests, a head-to-toe assessment is a procedure carried on a patient's bod parts from the head throughout to the toe. It should be done each time you encounter a patient for the first time each shift (or visit, for home care, clinic or office nurses). An accurate assessment requires an organized and systematic approach using the techniques of inspection, palpation, percussion, and auscultation.

It also requires a trusting relationship and rapport between the nurse and the patient to decrease the stress the patient may have from being physically exposed and vulnerable. The patient will be much more relaxed and cooperative if you explain what will be done and the reason for doing it. While the findings of a nursing assessment do sometimes contribute to the identification of a medical diagnosis, the unique focus of a nursing assessment is on the patient's responses to actual or potential problems.

Considerations in preparing a patient for a physical assessment

a. **Establish a Positive Nurse/Patient Rapport.** This relationship will decrease the stress the patient may have in anticipation of what is about to be done to him.

b. **Explain the Purpose for the Physical Assessment.** The purpose of the nursing assessment is to gather information about the patient's health so that you can plan individualized care for that patient. All other steps in the nursing process depend on the collection of relevant, descriptive data. The data must be factual, not interpretive.

c. **Obtain an Informed, Verbal Consent for the Assessment.** The chief source of data is usually the patient unless the patient is too ill, too young, or too confused to communicate clearly. Patients often appreciate detailed concern for their problems and may even enjoy the attention they receive.

d. **Ensure Confidentiality of All Data.** If possible, choose a private place where others cannot overhear or see the patient. Explain what information is needed and how it will be used. It is also important to convey where the data will be recorded and who will see it. In some situations, you should explain to the patient his rights to privileged communication with health care providers.

e. **Provide Privacy From Unnecessary Exposure.** Assure as much privacy as possible by using drapes appropriately and closing doors.

f. **Communicate Special Instructions to the Patient.** As you proceed with the examination, inform the patient of what you intend to do and how he can help, especially when you anticipate possible embarrassment or discomfort.

Equipment needed

Stethoscope

Thermometer

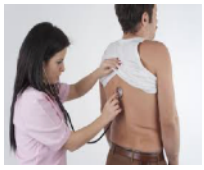
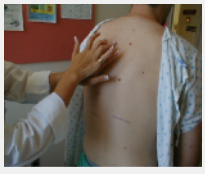
Sphygmomanometer

Penlight

Tape measure

Watch with second hand

Basic techniques needed

Technique	Definition	Notes
Inspection 	Visual examination of a person is called inspection. This is done in an orderly manner, focusing on one area of the body at a time.	
Palpation 	Examination by touch is called palpation. The nurses feels for texture, size, consistency, and location of body parts.	
Auscultation 	Examination by listening for sounds produced within the body is called auscultation. The sounds most frequently listened for are those of the abdominal and thoracic viscera and the movement of blood in the cardiovascular system. Direct auscultation, using the ear only, is seldom done. Indirect auscultation is generally carried out with a stethoscope.	
Percussion 	Examination of the body by tapping it with the fingers is called percussion. Percussion is a special assessment skill that the practical nurse is not required to perform. This technique is usually performed by a registered nurse (RN) or a physician.	

Assessment Procedure

5 Vital Signs

1. Wash your hands.
2. Greet and identify the patient.
3. Explain what you are going to do.
4. Provide for privacy.
5. Check the 5 Vital Signs:
   - Temperature
   - Pulse
   - Blood Pressure
   - Respiration
   - Pain
6. Ask the patient how he/she feels and observe the environment.

   Note: As you assess the body by systems, observe for such things as non-verbal cues, mobility and ROM.

Skin, hair, and nails

As you examine all body systems you need to make note of the status of the Integumentary System for any breaks in the skin, scars, lesions, wounds, redness, or irritation. Assess the turgor, color, temperature and moisture of the skin.

This is not a specific step. Evaluating the skin, hair, and nails is an ongoing element.

- **Inspect skin color**
  - Pale, white ashen appearance, i.e. Pallor, may be a sign of shock!
  - Bluish, gray skin, i.e. Cyanosis, shows poor oxygenation of the blood
  - Yellowish-orange skin, i.e. Jaundice, may be a sign of liver disease or blood disease
- **Inspect scalp** for lesions and hair and scalp for presence of lice and/or nits.
- **Inspect nails** for consistency, colour, and capillary refill.

HEENT

1. **Head**
   - check shape and symmetry
   - check condition of hair and scalp

2. **Eyes**

- check conjunctiva and sclera, pupils;
- check reactivity to light and ability to follow your finger or a light
- check eyes for drainage, pupil size, and reaction to light; drainage may indicate infection, allergy, or injury; pupils are normally are the same size and react equally to light.

3. **Ears**

- check if patient is using hearing aids
- check for pain
- speak in a whisper; can the patient hear you and comprehend? turn away to make sure patient isn't reading your lips

4. **Nose**

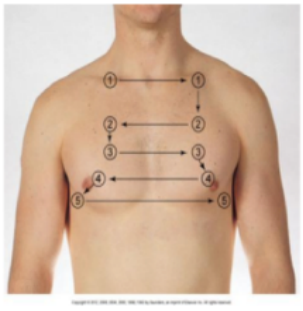
- check drainage, congestion, difficulty breathing, sense of smell

5. **Throat and Mouth**

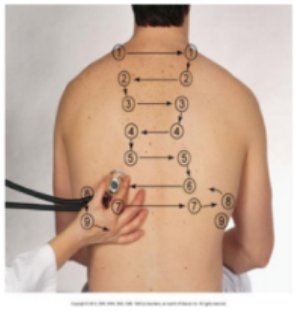
- check mucous membranes, any lesions, teeth or dentures, odor, swallowing, trachea, lymph nodes, tongue

Chest

1. Ask the patient to breathe in and out normally through their mouth.
2. Use diaphragm of stethoscope
3. Anterior chest: auscultate from side to side and top to bottom.
4. Auscultate over equivalent areas and compare the volume and character of the sounds and note any additional sounds.
5. Compare sounds during inspiration and expiration and note location and quality.
6. Posterior chest: auscultate from side to side and top to bottom.
7. Assess vocal resonance. Ask the patient to say 'ninety-nine, ninety-nine' and compare the sounds at equivalent positions on each side of the chest.



Anterior Chest

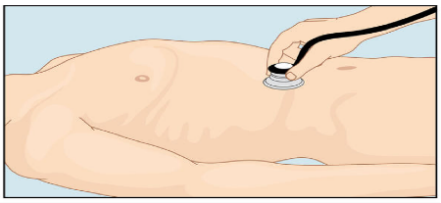


Posterior Chest

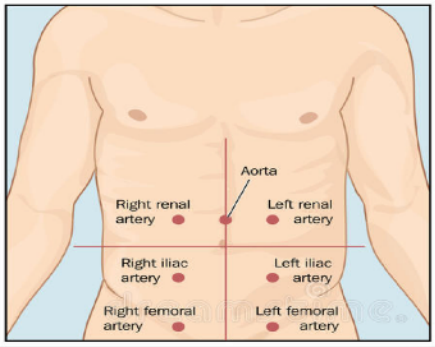
- Chest expansion may be asymmetrical with conditions such as atelectasis, pneumonia, fractured ribs, or pneumothorax.
- Use of accessory muscles may indicate acute airway obstruction or massive atelectasis.
- Jugular distension of more than 3 cm above the sternal angle while the patient is at 45° may indicate cardiac failure.
- The presence of crackles or wheezing must be further assessed, documented, and reported. Unusual findings should be followed up with a focused respiratory assessment.

Abdomen

1. Inspect abdomen for distension, asymmetry
2. Auscultate bowel sounds (RLQ)



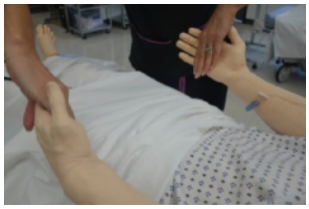
3. Palpate four quadrants for pain and bladder/bowel distension (light palpation only)
4. Check urine output for frequency, colour, and odour.



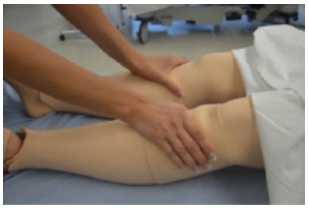
5. Determine frequency and type of bowel movements.

Extremities

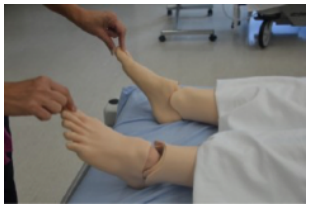
1. Assess for temperature, capillary fill and ROM.
2. Palpate for pulses.
3. Note any edema, lesions, lumps or pain.
4. Upper Extremities
   - 4.1. Assess CWMS (color, warmth, movement, and sensation)
   - 4.2. Check circulation: capillary refill - report if more than 3 seconds, radial pulses
   - 4.3. Check motion / sensation: hand grasps
     - Push/pull
     - Straight arm raise



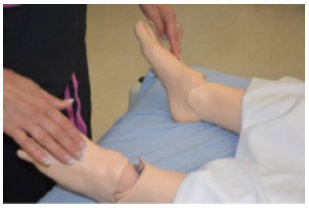
Assessing bilateral hand strength



Assessing CWMS

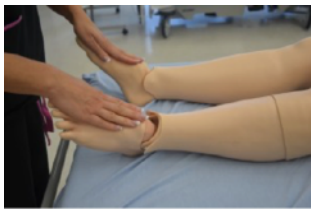


Assessing bilateral hand strength

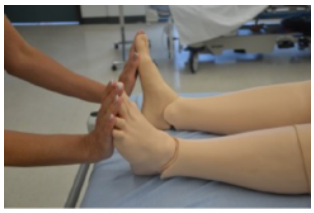


Assessing CWMS

5. Lower Extremities
   5.1. Assess CWMS (color, warmth, movement, and sensation)
   5.2. Check circulation: Capillary refill, posterior tibial and dorsalis pedis pulses
   5.3. Check motion / sensation:
      - Push/pull
      - Leg raise



Assessing plantar flexion



Assessing dorsiflexion

Back area (turn patient to side or ask to sit up or lean forward)

Inspect back, spine, and coccyx / buttocks.

- Check for curvature or abnormalities in the spine.
- Check skin integrity and pressure areas, and ensure follow-up and in-depth assessment of patient mobility and need for regular changes in position.

General Questions

Ask the patient how he feels.

- Has anything changed recently?
- Any pain, burning, SOB, chest pains, change in bowel or bladder habits/function, change in sleep habits, cough, discharge from any orifice, depression, sadness, or change in appetite?

Wash your hands

- Document your findings.
- Report any significant changes or findings to the PCP (primary care practitioner).

Evaluate your assessment in terms of The Nursing Process

Sample conversations during general assessment

How to establish rapport and ask the reason for consulting a physician

Doctor / Nurse: "Good day Mr [*Patient's last name*]. What brought you here today?"

Note: Patients should be asked their reason for seeking medical help. It is important to get the expressed health concern or chief complaint in the patient's own words. If the illness is chronic, they should be questioned as to what changes in their condition prompted them to seek help or when they last felt well.)

How to inform the patient about the assessment

Doctor / Nurse: "I will be taking a health history and performing a physical assessment to help meet your health care needs. The assessment will also provide a baseline picture of your health status so that we can notice any changes in your condition."

How to get information about patient's occupation and social activity

Doctor / Nurse: "May I know your present occupation?"

Note: Current occupations may be different than what a person normally does (for example the produce worker in the market may be a coal miner who is temporarily unable to perform his/her usual occupation.

Doctor / Nurse: "What about your usual occupation?"

Doctor / Nurse: "Any other jobs you may have had?"

Note: Provides information about possible health risks and psychosocial information.

Doctor / Nurse: "Have you ever joined the military?"

Note: Allows the examiner to assess if the patient has been exposed to a typical substances such as Agent Orange or out-of-country microorganisms. Also can provide psychosocial information.

How to know whether the illness was acquired from another country or not

Doctor / Nurse: "Have you travelled recently?"

Doctor / Nurse: "Any other countries you have visited? When was that?"

Note: People oftentimes bring home more than just souvenirs from out of country trips. Unexplained skin conditions and gastrointestinal problems may have originated from exposure to unfamiliar microorganisms. Note

the location of the travel and the length of time since returning home.

How to get information regarding childhood illness and immunization

Doctor / Nurse: "Have you experienced any type of disease during childhood?"

Doctor / Nurse: "Can you still remember the immunizations you have had?"

Note: If appropriate, ask questions about the person's history of varicella, polio, measles, mumps, and rubella. Also ask about the person's DPT status and last immunization for tetanus.

How to get information about medical and surgical history

Doctor / Nurse: "Have you ever been hospitalized?

Doctor / Nurse: "What was the reason for the hospitalization? Can you still recall the date?

Note: Reasons for hospitalizations, years of occurrence, and outcome of illnesses should be assessed.

Doctor / Nurse: "Do you have any past major illness?" or "What is the sickest you have ever been?"

Doctor / Nurse: "Have you undergone any surgical procedure?"

Doctor / Nurse: "What about injuries or fractures?"

Note: Past history of serious injuries and fractures should be established. Patients can be asked if they have ever been in a serious automobile or industrial accident.

How to assess whether patient has allergy or not

Doctor / Nurse: "Do you have any drug, food, or airborne allergy?"

Note: The patient should be questioned as to food, drug, and airborne allergies. Reactions to allergens should be established. Assess past and current treatment for allergic reactions.

Doctor / Nurse: "Are you currently taking any medications including over the counter drugs and folk medicines."

Doctor / Nurse: "Can you please tell me the name, dosage, and frequency?"

How to ask personal questions pertaining to lifestyle

Doctor / Nurse: "Do you smoke?"

Doctor / Nurse: "How many cigarettes can you smoke in a day?"

Doctor / Nurse: "Do you drink alcohol?"

Doctor / Nurse: "Have you ever thought you drank too much? Or have your family or friends ever complained about the amount you drink?"

Doctor / Nurse: "Have you tried using narcotics?"

Doctor / Nurse: "Do you exercise?"

Doctor / Nurse: "Are you sexually active?

Doctor / Nurse: "Now, let's talk about your family's health status. Are any of your parents presently ill? What about your siblings? What about your spouse and children?"

Doctor / Nurse: "Any hereditary illness you are aware of on both mother and father side?"

Sample Script for Head-to-Toe Assessment

Practice with your instructor or role-play.

Pull the curtain to provide for privacy, wash your hands.

Identify yourself by name and title. Make sure you explain to the patient what you are going to do

Check armband for positive ID, and while looking at the MAR to verify the information you ask these questions: **"Can you tell me your name? Can you tell me your date of birth? Do you know where you are? What day of the week is it?"**

"I have established my patient's level of consciousness, (LOC). The patient is alert and orientated."

"I now want to check your eyes by looking into them with a pen light. Just look straight ahead for me please (assess both pupils). Now look at my pen light and follow it as it comes closer to you."

Hold penlight in front of patient and bring in until about a 10-8" away from their nose watching for their eyes to follow it in. **"Patient's pupils are equal, round and reactive to light and accommodation."**

"Please open your mouth and slightly stick your tongue out." Use your penlight to view the inside of the mouth.

"I am assessing for moisture (hydration status) and color of the mucous membranes. They are pink and moist."

"Now I am going to listen to your heart and lungs."

"I am listening to the apical pulse (place stethoscope at the PMI- 5th ICS, LSB). Apical pulse has a regular rate and rhythm: no abnormal sounds are audible. This is also where I can best hear S1."

Now place the stethoscope at the aortic area. **"This is where I can best hear S2."**

"Now I am going to listen to the anterior lung sounds."

Compare bronchovesicular lung sounds in 1 location and vesicular lung sounds in 2 locations – watch your sequence! **"I will also listen to vesicular sounds in the lateral chest."**

Compare vesicular sounds in 1 location in the lateral chest area. **"Rate, and depth of respirations are regular. Anterior and lateral breath sounds are clear bilaterally, throughout all lung fields."**

Go to posterior thorax. **"Now I will listen to lung sounds in the posterior area."** Compare bronchovesicular lung sounds in 1 location and vesicular lung sounds in 2 locations. **"Posterior breath sounds are clear bilaterally, throughout all lung fields."**

While you are assessing the posterior lung sounds also assess for skin breakdown and sacral edema. **"Skin is intact in the sacral area with no edema."**

"Will you hold out your arms for me please?" Take patient's hands in yours.

"I am assessing skin color, temperature, and moisture. Skin is pink warm, and dry. I am also going to assess skin turgor."

Pinch skin on back of hand. **"Skin turgor is elastic and within normal limits. Next I am going to check your radial pulse."**

Palpate both radial pulses. **"They are strong and equal bilaterally. Now I am going to check for capillary refill."**

Depress the nail bed of one finger on each hand. **"Capillary refill is under 3 seconds, and within normal limits."**

"Please grasp my fingers using all of your strength. Now try not to let me pull away."

"Upper extremity grips and pulls are strong and equal"

"Please lie down on your bed. I am going to examine your abdomen now. Are you having any pain in your abdomen? Are you having any difficulties urinating? Are you having regular bowel movements? When was your last bowel movement?"

"I am inspecting the abdomen for shape/contour, scars, hernias or pulsations. Abdomen is symmetrical, slightly rounded (or flat, concave, etc.) and without pulsations or scars. Now I am going to listen to the abdomen." Start with the right lower quadrant and proceed clockwise. **"Bowel sounds are active (hypoactive, hyperactive) in all four quadrants."**

"I am now going to lightly touch (palpate) your abdomen. Please tell me if you have any discomfort while I am doing this." Palpate the abdomen using one hand in a circular motion in the same sequence as auscultation. Observe the patient face for non-verbal signs of discomfort.

"Abdomen is soft and non-tender".

"Now I am going to examine your legs and feet."

"I am going to assess the skin for color, temperature and any presence of edema in the legs. I am also going to check the bottom of their heels to assess for redness, and non-blanching skin as s/s of breakdown. I am next going to check the pedal pulses bilaterally, and the capillary refill of the toe nail bed." Check pedal pulses and cap refill.

"Skin is pink, warm and dry with no edema, or signs of breakdown. Pedal pulses are strong bilaterally and capillary refill is less than 3 seconds."

"Now please press your feet against my hands like you are stepping on a gas pedal."

"I'm assessing the patient's lower extremity strength bilaterally. Pushes are strong and equal bilaterally."

"This completes my examination. Do you have any questions or concerns I can answer?" If not, make sure the patient is comfortable and say ***"here's your call light if you need any assistance before I return"***. Give the patient the call light.

Return the bed to its lowest position, open the curtain, wash your hands and leave the room. Document your findings in the patient's care record.